# Montana Office of Vital Records Newsletter

## Thank You All for Your Patience with our Recent Technical Issues

The Office of Vital Records wants to thank our wonderful data providers for all your patience and understanding throughout the last several weeks while on-line services were unavailable.

Many of you have read the press release concerning the incident where hackers gained entry to a Department of Public Health and Human Services (DPHHS) computer server. Please be assured that there is no evidence that information on the server was used inappropriately, or was even accessed.

This incident did cause some DPHHS systems, including VSIMS, to be temporarily unavailable. VSIMS is back up and running, although some of our Vital Records end users continue to run into problems submitting or printing records. The problems are generally easy to fix, often requiring only refreshing your connection to us. Please call us if you continue to have difficulties and we will walk you through the steps to get back on line.

If you receive questions from the public about the security of their personal information submitted to the Office of Vital Records, you can refer them to the DPHHS helpline:

1-800-809-2956

We greatly appreciate your patience and cooperation during the recent inconvenience.

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**You can find copies of earlier newsletters at our website:**

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MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

# Meet the Vital Statistics Analysis Unit Staff

Left to right: Anna Walker, Senior Research Statistician; Bruce Schwartz, Lead Vital Statistics Epidemiologist; Sarah Price, Data Quality Specialist.

The Vital Statistics Analysis Unit is located in the Office of Epidemiology and Scientific Support. Like the Office of the Registrar, it is part of the Public Health and Safety Division.

The VSAU works closely with the Registrar's staff in a variety of Quality Improvement initiatives such as the Birth Registration Score Cards that we sent out in our first Newsletter.

The VSAU publishes the Montana Vital Statistics Annual Report and a variety of special reports each year.

In addition, the Vital Statistics Analysis Unit responds to a wide variety of queries from other programs in the DPHHS, other state agencies, the legislature, academic partners, and the press.

Our publications can be found at our website.
http://www.dphhs.mt.gov/statisticalinformation/vitalstats/index.shtml

We will provide alternative formats of all our publications on request. Please contact Sarah at sprice@mt.gov or 406-444-6092.

# Certificate of Birth Resulting in a Stillbirth

Montana requires that a pregnancy resulting in the death of a fetus weighting 350 grams or more receive a fetal death certificate. Effective January 1, 2008, these fetal deaths are also automatically issued a Certificate of Birth Resulting in a Stillbirth. A Certificate of Birth Resulting in a Stillbirth can also be issued if the fetus did not weight 350 grams, but had achieved a minimum of 20 weeks gestation, if the parents request it.

The hospital where the stillbirth occurred, or the funeral home assuming responsibility for disposition, may file the certificate with the Office of Vital Records, at the request of the parents. Parents may also contact the Office of Vital Records directly at a later date to request a Certificate of Birth Resulting in a Stillbirth.

For losses that occurred prior to January 1, 2008, parents may request a Certificate of Birth Resulting in a Stillbirth by contacting the Office of Vital Records.

Detailed instructions for filing a Certificate of Birth Resulting in a Stillbirth can be found in the current Preparer's Handbook, available at
http://www.dphhs.mt.gov/forms/results.jsp?catchoose=10&keywords=

# Birth Registration Gold Star for Excellence Recipients

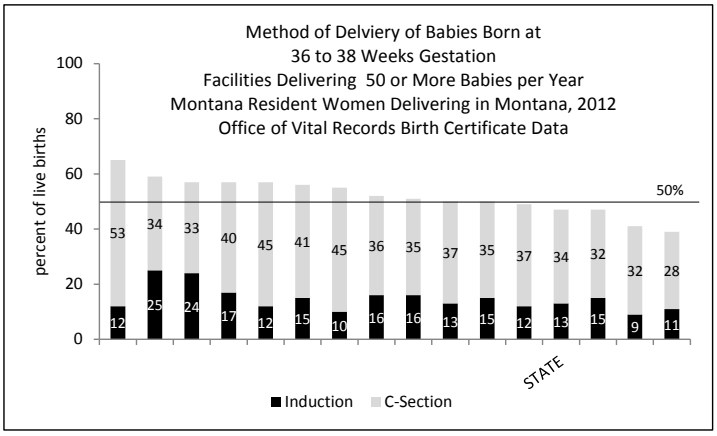


The following facilities received birth registration Gold Stars for Excellence for the first Quarter of 2014. More than 90% of their births were registered within 10 days, above the state average performance for the quarter. The new state average of 90% for the first quarter of 2014 is an increase over the 85% state average for the baseline year of 2013.

Anaconda Community Hospital
Barrett Hospital and Healthcare
Big Horn County Memorial Hospital
Billings Clinic
Birth Center of Missoula
Central Montana Hospital
Clark fork Valley Hospital
Family Birth Center
Frances Mahon Deaconess Hospital
Great Falls Family Birth Center
Holy Rosary Healthcare
Kalispell Regional Medical Center
Marcus Daily Memorial Hospital
Missoula Community Medical Center
North Valley Hospital
Northern Montana Hospital
St. James Healthcare
St. Joseph Hospital
St. Vincent Health Care
Sidney Health Center

# Initiative to Reduce Early Elective Deliveries

The Montana Certificate of Live Birth records gestational age and method of delivery (spontaneous vaginal, cesarean with or without trial labor, induction). It also records some maternal risk factors that might contribute to the need for an early delivery, such as pre-existing or gestational diabetes, pre-existing or gestational hypertension (pre-eclampsia), and eclampsia. However, the birth certificate is not a complete maternal medical record and many conditions recognized by American Congress of Obstetricians and Gynecologists as indications for early delivery are not apparent from the birth certificate.




Based on Montana Certificates of Live Birth, 27% of live births in Montana occur between 36 to 38 weeks gestation, and 47% of them are delivered by induction or cesarean section. By facility, the rates of induction between 36 and 38 weeks gestation vary from 9% to 25%; rates of cesarean section vary from 28% to 53%. Even allowing for the fact that some larger facilities receive referrals of complicated pregnancies that are more likely to be candidates for medically-indicated early delivery, this wide range suggests that hospital policy and physician and patient choice play large roles in the timing and method of delivery.

The incidence of induction before 39 completed weeks of gestation in the US increased from 10% of live births in 1990 to 24% in 2008; cesarean deliveries increased from 23% to 33%.[1] It is unlikely that the prevalence of medical necessity for early delivery increased at the same pace. The bulk of the increase in early inductions and cesarean sections has been attributed to a substantial increase in *elective* early deliveries.[2] There is no evidence that early elective delivery provides any health benefit to the mother or infant, and ample evidence that early delivery incurs increased risk for both.[3]

Many health care organizations in the United States are adopting the March of Dimes toolkit for reducing early elective deliveries.[2] It is a comprehensive approach engaging stakeholder organizations, hospital administrators, physicians, and peer review panels to ensure that induced or cesarean deliveries before 39 weeks completed gestation are medically indicated. Marked reduction in early elective deliveries has been reported after adopting the toolkit. Intermountain Healthcare of Utah and Idaho reduced elective deliveries before 39 weeks from 28% to 10% within six months and maintained a rate less than 5% for the next six years. Magee Women's Hospital in Pittsburgh reduced its rate from 12% to 4% in 14 months. Hospitals in the Ohio Perinatal Quality Collaborative reduced their rates from 13% to 8% in 14 months.

Montana's current rate of early elective delivery is similar to national rates in the absence of initiatives to reduce them. The Montana Department of Public Health and Human Services is participating with several birthing hospitals statewide in a new initiative to reduce early elective deliveries.

1. National Center for Health Statistics, National Vital Statistics Reports. *Births: Final Data for 2008.* Vol. 57, no. 7. Bethesda, MD: NCHS, 2010.
2. Main E, et al. *Elimination of Non-Medically Indicated (Elective) Deliveries Before 30 Weeks Gestational Age*. San Francisco: March of Dimes, 2010.
3. http://www.acog.org/Resources_And_Publications/Committee_Opinions/Committee_on_Obstetric_Practice/Nonmedically_Indicated_Early-Term_Deliveries; American Congress of Obstetricians and Gynecologists. ACOG Committee opinion no. 560: Medically indicated late-preterm and early-term deliveries. *Obstet Gynecol* 2013: 212:908-910.

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